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ABSTRACT

Nonbehavioral approaches to marital therapy have only recently become subject to empirical validation in contrast to extensively researched behavioral approaches. Behavioral marital therapy outcome research was examined as a reference point for evaluating the outcome studies of four nonbehavioral marital approaches: insight-oriented, cognitive, systemic, and experiential. For this study 19 nonbehavioral marital therapy outcome studies in addition to several meta-analysis studies relevant to therapy outcome research were reviewed. Insight-oriented marital therapy appears to be at least minimally effective when directive interventions are excluded from the treatment. When included, one insight-oriented approach appears to offer a therapeutic efficacy equal to that of Behavioral Marital Therapy (BMT), and perhaps superior to BMT in respect to long-term gains. Cognitive marital therapy also appears to be relatively ineffective when behavioral interventions are excluded from the treatment. The findings for systemic marital therapy must be viewed as tentative because there were only two direct outcome studies. These treatments were generally as effective as the behavioral components to which they were compared, but they showed a tendency toward greater deterioration of treatment gains. Two models of experiential marital therapy were reviewed, and both evidenced a measure of effectiveness with distressed couples. Nonbehavioral approaches generally appear to be as effective as behavioral approaches, and possibly more effective when intrapersonal elements are emphasized. (LLL)

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NONBEHAVIORAL MARITAL THERAPY: A REVIEW OF OUTCOME RESEARCH

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Roger Allen Bryant

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NONBEHAVIORAL MARITAL THERAPY: A REVIEW OF OUTCOME RESEARCH

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ABSTRACT

NONBEHAVIORAL MARITAL THERAPY: A REVIEW OF OUTCOME RESEARCH

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Roger Allen Bryant

Nonbehavioral approaches to marital therapy have only recently become subject to empirical validation in contrast to extensively researched behavioral approaches. A summary of outcome research of behavioral marital therapy outcome research is presented as a reference point for evaluating the outcome studies of four nonbehavioral marital approaches: insight-oriented, cognitive, systemic and experiential. This paper reviews 19 nonbehavioral marital therapy outcome studies in addition to several meta-analysis studies relevant to therapy outcome research. Nonbehavioral approaches generally appear to be as effective as behavioral approaches, and possibly more effective when intrapersonal elements are emphasized. Many more outcome studies are needed to evaluate the efficacy of nonbehavioral approaches to marital therapy. It is recommended that future research focus on change processes in addition to matching therapeutic interventions more specifically to couples' presenting problems and needs.

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Nonbehavioral Marital Therapy: A Review of Outcome Research

Introduction

Marital therapy is a relatively young specialization within family therapy. As recently as 1957 the literature on marital therapy was reviewed to determine the "knowns and unknowns" of research but no empirical studies could be found to summarize (Mudd, 1957). Manus (1966) viewed marriage counseling as "a technique in search of a theory," describing the specialization in the mid-sixties as one in which "there is a clear picture of inconsistency, contradiction and lack of a coherent theory" (p. 452). It was further criticized at that time as having a widely accepted body of principles that had not been tested empirically (Leslie, 1964). Thus, in both theory and research marital therapy has shown limited development until relatively recently.

In the last two decades behavioral researchers have responded vigorously to these challenges. They have generated a considerable body of knowledge about marital interaction, sought to ground their techniques in theory, and have demonstrated through outcome research the efficacy of Behavioral Marital Therapy (BMT) as a treatment approach. During most of the same period, however, nonbehavioral

therapists and researchers have engaged widely in treatment and theorizing but have been almost silent in terms of meaningful outcome research (Baucom & Hoffman, 1986; Jacobson & Margolin, 1979). It appears now that some of these empirical deficiencies are beginning to be addressed within the non-behavioral approaches, opening up the possibility of developing additional and more effective approaches to marital therapy.

There is no question that there is a critical need for the further research and development in the field of marital therapy. More individuals seek help in mental health clinics for marital problems than for any other single problem, and nearly 40% of all clients in mental health clinics have indicated that marital problems are part of their difficulty (Yerloff, Kulka, & Douvan, 1981). While it seems to hardly draw attention anymore to mention the 50% divorce rate in the United States, nonetheless it is the highest among major industrialized countries of the world (U.S. Bureau of the Census, 1990). Further, the consequences of marital discord and divorce are broad and deep. Depression and suicide among adolescents and young adults in the United States is at an all time high. One reason postulated for this is the change in family structure with its attendant high rates of marital dissolution (Klerman & Weissman, 1990). Adult psychopathologies such as alcoholism and depression are also becoming more

conclusively linked to marital discord (Beach, Sandeen, & O'Leary, 1990; Jacobson, Holtzworth-Munroe, & Schmaling, 1989). Clearly these appear to be problems that will not abate without effective intervention.

Definitions and Overview

The term nonbehavioral marital therapy may be rather misleading. It encompasses as a collective term not one but many approaches to marital therapy, and in apparent contradiction to its name does not necessarily exclude some form of behavioral intervention. It is used here particularly as a convenient way of referring to a group of approaches to marital therapy that are not based primarily on theories of Behavioral Exchange (Thibaut & Kelley, 1959) and Social Learning (Bandura, 1969). Nonbehavioral marital therapy stands in contrast to Behavioral Marital Therapy (BMT) which represents a more distinct theoretical approach to the treatment of marital couples. More specifically, as used in this paper the term nonbehavioral marital therapy encompasses four theoretically different marital treatment approaches: (a) insight-oriented, (b) cognitive, (c) systemic, and (d) experiential.

The task in this paper is to review the marital therapy outcome research that has been conducted on each of these major nonbehavioral orientations. Outcome studies are those studies designed to measure some facet of psychological adjustment or interpersonal functioning upon completion of

treatment (posttreatment). The purposes of this review are (a) to evaluate the efficacy of the nonbehavioral approaches, (b) to consider the unique contributions or limitations demonstrated by each in respect to the practice of marital therapy, and (c) to assess their ability to address some of the apparent clinical deficits of BMT.

Because the nonbehavioral approaches are implicitly and, in some cases explicitly, being compared to BMT as a "known quantity," it seems helpful for purposes of comparison to review the theory, therapy and outcome research for BMT. The limitations or deficits of BMT are also discussed for the purpose of highlighting critical areas of intervention that nonbehavioral marital therapies may be better able to address. Because the focus of this paper is on nonbehavioral outcome research, the rather large corpus of BMT outcome research is merely summarized.

Behavioral Marital Therapy

BMT has its roots in Thibaut and Kelley's (1959) Social Exchange Theory and in Bandura's (1969) Social Learning Theory. It is designed to teach and shape couples' skills to maximize gains and minimize losses with their partner. This approach has been variously referred to as "quid pro quo" (Stuart, 1976), a "give-to-get equilibrium" (Weiss, 1978), and "rational bargaining" (Johnson, 1986).

Modifications and changes in the early 1980s brought into BMT contingency contracting (behavioral exchange)

supplemented by training in problem-solving, communication skills and relationship enhancement strategies. All of these emphasize immediate changes in the couple's interactions and the development of relationship consistency. The therapist serves an educative role for the couple by presenting a model for effective marital interactions and by describing specific recommended behaviors. The therapist also has a skill-training function as he or she models behaviors, has the couple rehearse them, and then gives the partners feedback to shape and help them acquire specific interpersonal skills.

In the early approaches of BMT, the therapist would steer away from exploration of feelings, ventilation and analysis of motivation. Attribution of responsibility to other persons also tended to be minimized. The assumption was that behavioral changes would be sufficient to bring about more positive feelings and thoughts and lead the couple to renewed intimacy. As BMT has evolved, this assumption has been modified with resulting changes in therapist behavior (Jacobson & Holtzworth-Munroe, 1986).

Researchers have sought to demonstrate the efficacy of BMT as a treatment approach in numerous outcome investigations. At least two dozen studies and several reviews have made it "the most frequently evaluated therapy for the treatment of discordant couples" (O'Leary & Smith, 1991, p. 202). In clinical studies across the United States

and Europe, BMT has been shown repeatedly to be a therapy which results in a decrease of negative verbal behavior and a significant increase in marital satisfaction (Beach & O'Leary, 1985; Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984; Jacobson, Follette, & Elwood, 1984). Initial indications were that 70-80% of the couples treated in this way improve (Baucom & Hoffman, 1986). However, later reviews of these same studies applying more stringent criteria reveal a slightly different picture. Jacobson, Follette, Revenstorf, Baucom, Hahlweg, & Margolin (1984) reported that slightly more than half of the couples showed improvement, but only about one third actually changed their status from distressed to nondistressed by the end of therapy. In about 40% of the improved couples, positive changes were confined to one spouse. Of those couples who showed improvement, about 60% had maintained the gains at six-month follow-up. Another review reported similarly that only 40-55% of couples showed enough improvement with BMT to be classified as nondistressed (Baucom & Epstein, 1990). From the perspective of maintaining the gains of therapy, Jacobson, Schmaling, and Holtzworth-Munroe (1987) identified significant deterioration in 27-42% of couples across three (behavioral) treatment conditions between the first and second-year follow-up.

In addition to the picture of mixed success regarding clinical results, many criticisms have been leveled at BMT

from both behavioral and nonbehavioral therapists. From a psychodynamic-systems perspective, the objection has been made that BMT focuses too much on rational control and fails to give attention to the idiosyncratic meaning of behavior (Gurman, 1978). Further, it is argued that not all marital disharmony derives from the same source (lack of positive reinforcement/reciprocity) and that simply changing behaviors does not insure that the partners' perceptions of or feelings toward each other will change (Benunn, 1985, 1987; Johnson, 1986). Among the behavioral therapists themselves, it has been affirmed that some specific marital problems, particularly those related to "passion, play, ... and fairness" and the enhancement of intimacy, are not amenable to skills-oriented intervention (Hahlweg et al., 1984; Margolin, 1983). Other criticisms have implied that BMT focuses too much on the dyad rather than on the individual, over-emphasizes behavioral and reciprocal change to the relative exclusion of cognitive, perceptual and affective processes, and is insensitive to sex role issues (Benunn, 1985).

BMT researchers have responded to some of these criticisms in recent years by giving more attention to the irrational beliefs of the couple, affective and verbal reactivity, attributional processes of the spouse and a general emphasis on the affective mode of mental processing. A few studies of integrated approaches have also been

conducted that have specifically incorporated components of cognitive, systemic, mediational and affective-oriented marital treatment strategies. The outcome results in respect to these combined approaches are mixed. Some appear to offer slight improvement over the standard BMT approach, others do not (Baucom & Lester, 1986; Baucom, Sayers & Sher, 1990; Emmelkamp, van der Helm, Mac Gillavry, van Zanten, 1984).

These integrative approaches are interesting but raise some potentially problematic issues given the diverse theoretical orientations involved. Lebow (1984), for example, suggested that theoretical integrations may result in "an atheoretical definition of concepts without a connection between a conceptualization of the human condition and practice" (p. 135). Ironically that would likely bring marital therapy almost full circle to its earlier status as a "technique in search of a theory."

A second issue involves the increasing complexity of an integrated approach and whether other nonbehavioral strategies can be accurately incorporated by behaviorally oriented clinicians/researchers. Can an "emotionally focused" intervention, for example, be employed effectively by someone not trained in that orientation?

A third issue may be even more significant. Johnson (1986) suggested that some of the most significant problems within BMT are deeper than the addition or integration of

new techniques can resolve. She argued that perhaps the whole rational bargaining or exchange paradigm of intimate relationships needs to be revised or possibly replaced by one that views the relationship as an emotional bond.

In summary, BMT has been established as the leader and a known standard in terms of a theoretically grounded, empirically tested marital treatment approach. Through outcome research it has demonstrated a moderate degree of efficacy in helping distressed couples improve their marital relationship. It has apparent deficits in being able to address certain, perhaps key, aspects of the relationship, but researchers continue to test and incorporate new strategies that may lead to increased effectiveness and breadth of application.

Method

The literature search for this review was conducted in several ways. Psychological Abstracts (Vols 72-76, 1985-89) and the Inventory of Marital and Family Literature (Vols 8-14, 1981-1987) were the initial sources utilized, with the focus on outcome research in marital therapy. PsychINFO (computer disk based, 1974-March, 1991) was also searched first using key words "marriage counseling" crossed with "treatment outcome." Further studies were accessed by specifically reviewing all of the various nonbehavioral therapies listed (e.g., brief, cognitive, communication

training, existential, experiential, expressive, gestalt, insight-oriented, object-relations, psychodrama, psychodynamic, relationship enhancement and systems). Previous literature reviews and references of several marital handbooks were also searched (Gurman & Kniskern, 1978; Gurman, Kniskern, & Pinsof, 1986; Gurman & Rice, 1975; Hahlweg & Jacobson, 1984; Jacobson & Gurman, 1986; L'Abate, 1985; Paolino & McCrady, 1978), in addition to the references of each book and article cited in this paper. The time span for the outcome studies reviewed in the present paper extends from 1978 through March, 1991.

Inclusion/Exclusion Criteria

Studies that were selected for inclusion in the present review met several criteria. First, they clearly specified the focus of treatment to be the marital dyad rather than individual or family therapy. Although these other approaches are often used in the treatment of marital problems, they introduce other factors that could not be covered in the scope of this paper.

Second, they clearly specified having utilized a theoretical and/or clinical approach that fits one of the nonbehavioral approaches described above: insight-oriented, cognitive, experiential or systems. Unfortunately, due to the limited amount of outcome research within nonbehavioral approaches, some of the studies involved treatments that combined nonbehavioral and specified behavioral components.

Further, some of these combined treatment studies were conducted by researcher-clinicians with an obvious behavioral orientation (Baucom & Hoffman, 1986). These factors present a potential confound, but an attempt has been made to discern the impact of the treatment components unique to the nonbehavioral treatments. This same confound inevitably arises with even the supposedly "pure" nonbehavioral treatments, because many of them also utilize directive and behavioral strategies. A similar perspective of discriminating the impact of the unique nonbehavioral aspects has been adopted for all of the studies.

It could be reasonably argued that the communications approaches, in particular Bernard Guerney's Relationship Enhancement approach, should also be considered a major nonbehavioral treatment. It is based on Rogers' client-centered approach and is well represented in the outcome research literature. It is described as representing an interpersonal orientation, an integration of psychodynamic, humanistic and behavioral schools, however, its dominant theoretical concepts and methodology are behavioral (Guerney, Brock, & Coufal, 1986). To a significant degree, it overlaps conceptually and in practice with the more behavioral communication-training programs which emphasize problem-solving strategies (Beach & O'Leary, 1985), and it has in fact been largely incorporated as a component within BMT (Jacobson & Holtzworth-Munroe, 1986). Relationship

Enhancement was therefore excluded from the present review because it was considered too difficult to differentiate it from the behavioral approaches.

Third, all of the studies included in the review involved actual treatment with distressed couples, rather than analogue studies, marital enrichment or prevention programs. It was felt that this criterion would yield the best measure of actual efficacy of a marital treatment.

Fourth, the studies selected excluded marital intervention that was targeted toward (a) specific relationally defined problems, e.g., marital violence, sex-role issues; (b) marital sub-populations, e.g., remarried couples, separation/divorce therapy; and (c) particular psychiatric disorders, e.g., depression, alcoholism. These are important applications of marital therapy, however, they introduce other variables which complicate the evaluation of an approach as a generic marital therapy. A significant drawback to this criterion, however, is that excluding studies directed toward specific marital populations may inadvertently conceal the strengths of a particular approach; it may be with those special populations that the approach is most effective. Although not many nonbehavioral outcome studies were found generally, particularly studies applying a specified nonbehavioral approach to one of the conditions noted above, future reviewers may need to consider such specific applications of marital therapy

approaches as the empirical literature becomes more substantive.

Finally, the studies selected for inclusion were focused on outcome research. This included both measured evaluations of effectiveness of a particular treatment approach and identification of factors that appear to predict its effectiveness. Single-case studies were not included and the majority of the studies utilized objectively measured criteria and control groups.

Methodological Issues

One of the most important problems regarding outcome research in general relates to the specification of the independent variable (Beach & O'Leary, 1985). Unlike laboratory research, the conditions of treatment are more difficult to define and control, especially in the case of psychotherapy outcome. The varying needs and presenting problems of clients inevitably require some flexibility in technique and usually involve months of interpersonal contact between therapist and client. Thus, it is difficult to know what condition is actually being evaluated or compared and how it relates to some theory of intervention.

The second selection criterion noted above highlights another aspect of this same research problem. Integration and overlap of methods and theory from competing approaches to psychotherapy is a well recognized trend in the literature. A few marital therapy approaches have training

manuals that specify the treatment methodology, but even when these are strictly followed they do not rule out the confound of shared methodology between approaches.

A related issue involves how treatment effectiveness is measured. One approach is to compare the specific treatment and a no-treatment control group, while another is to compare different modalities. Most researchers agree that without a control group, the results of comparative studies may leave significant doubt about the actual level of effectiveness. Individual studies can also be summarized by conducting a meta-analysis which compares multiple studies. Four meta-analysis studies that are relevant to this issue of treatment measurement and comparative treatment approaches studies are reviewed at the beginning of the next section. Those studies were not limited to marital therapy, but many of the findings apply to marital therapy outcome research.

The measured effectiveness of any treatment is also partially a function of the measurement device and how it is used. Inherent in this matter as it relates to marital therapy is the problem of operationalizing "improvement." Most studies on marital therapy have compared only the mean scores of the treatment groups. This provides useful information, but does not help the clinician predict whether a specific couple is likely to benefit from the treatment nor does it predict the extent of change that can be

expected. Improvement has often been operationalized by an increase or decrease in the subject's score on a specific test instrument, without accounting for its measurement error. This is problematic because some of the improvement could be an artifact of the measurement error in the instrument and thus not true improvement.

Improvement has also been operationalized as the direction of change due to therapy, but whether the couple was still distressed or not was often ignored. The distinction between distressed and nondistressed is arbitrary and usually the mean score of the instrument provides the cut off point. This could be problematic were it assumed that improvement also means no longer distressed, or if it is assumed that a large amount of improvement is involved. Ideally, the hope is that significant change of scores on the instruments would correspond to real-life observable change in the relationship and that the couple would be left with a fully satisfying marriage. However, this is not generally the case. On the average, as noted above in respect to the outcome research on BMT, clients move from an extremely dissatisfied rating of their marriage at pretherapy to a just-satisfactory rating at posttherapy. It is generally agreed that more research is needed to understand how to influence the variables of love and intimacy in the relationship. Some of the experiential studies cited below begin to address this issue directly.

With these methodological issues in mind, the focus in this review is not particularly on comparing treatment approaches, that is, to determine which treatment is better or best. Rather, the intent, as stated above, is to determine if theoretically nonbehavioral approaches can demonstrate a clinically useful level of efficacy, and if so, what aspects of the treatment unique to the approach contribute to improvement. Hopefully, this may lead to more discriminate selection and/or integration of the effective components of alternative approaches.

Results of Outcome Research

There have been a number of previous reviews of marital therapy outcome research. In a comprehensive summary of marital and family outcome research up to 1978, Gurman and Kniskern (1978) found the data quite supportive of the overall efficacy of marital and family therapy. Specific to marital therapy, they classified 10 out of 15 studies as demonstrating the superiority of nonbehavioral methods over control conditions, while 7 out of 11 studies demonstrated the superiority of behavioral methods over control conditions.

Beach and O'Leary (1985) also provided an overview of outcome research, but the only nonbehavioral approach assessed was insight-oriented therapy. Beach and O'Leary stated they found none of the studies reviewed by Gurman and

Kniskern (1978) relevant to include in their review. Beach and O'Leary then cited three studies of insight-oriented marital therapy. These three are presented in this paper although one of them (Boelens, Emmelkamp, MacGillavry, & Markvoort, 1980) has been reclassified in this paper as a systems-oriented study in keeping with its self-described orientation.

Baucom and Hoffman (1986) also reported on the current status of marital therapy efficacy. They found only six suitable nonbehavioral studies, four of which are relevant to the present review. Their conclusion was that too few studies had been conducted, particularly by nonbehavioral researchers, to evaluate nonbehavioral approaches. Gurman, Kniskern, and Pinsof (1986) updated their review of the literature and evaluated the same four nonbehavioral studies and made essentially the same comments as Baucom and Hoffman (1986). Finally, O'Leary and Smith (1991) provided the most recent review of marital therapy but only briefly referenced two insight-oriented studies and one experiential study, all of are included in the present review. Overall, these previous reviews examined a total of six of the studies included in this paper: three insight-oriented, one systemic, and two experiential studies.

In regard to the methodological issue raised above about measuring the effectiveness of an approach through comparative treatment studies, Shapiro and Shapiro (1982)

conducted a meta-analysis study and found overall that less than 10% of the variance between outcomes could be accounted for by the different treatment modalities. Such things as nature of the target problem, measurement methods and instrument design were each greater predictors of the variance. Smith, Glass, and Miller (1980) as well as Berman, Miller, and Massman (1985) found that the allegiance of the researcher to a particular theoretical orientation and treatment approach was also a good predictor of the outcome. Another meta-analysis of comparative psychotherapy treatments was done by Kazdin and Bass (1989). They found that the power of studies was generally adequate to detect differences between treatment and no treatment because of large effect sizes. However, when effect sizes are small to medium, as is often found when alternative treatments are contrasted with each other, the power of the studies is generally too weak to detect significant differences. They suggested that the outcome measures used in the studies may be the primary source of the weakness.

In this section the nonbehavioral outcome research is reviewed. The basic theoretical principles, clinical goals and interventions are described, followed by a review and discussion of the outcome research involving specific approaches. Due to the variance among treatment strategies even within a single approach (e.g., insight-oriented), the distinctives of the treatment within each study are briefly

detailed. A summary of research findings and suggestions regarding clinical applications or further research concludes the review of each approach. Although results regarding behavioral treatments in comparative studies are presented for comparison purposes, they are not discussed in order to avoid focusing away from the nonbehavioral treatments.

Insight-Oriented Marital Therapy

The insight-oriented/psychodynamic orientation toward resolving marital conflict is the oldest and most widespread approach to treatment and has an important influence on the marital therapy scene today (Baucom & Hoffman, 1986). While it generally is not practiced as a pure psychodynamic form, these approaches typically emphasize the individual unconscious factors which are postulated as structuring the marital relationship.

Theory and therapeutic interventions. Two tenets are central to understanding the traditional psychodynamic view of marital adjustment and thus the focus of marital therapy. First, the psychodynamic perspective holds to a need-complementarity hypothesis, which is thought to influence both spouse selection and marital satisfaction. The hypothesis proposes that people consciously and unconsciously seek spouses who gratify their narcissistic needs (Dicks, 1967). Dynamic repression of these narcissistic needs and their introjection and projection

onto potential partners lead people to prefer spouses who complement their needs, or in other words, who best serve to substitute for some unattained ego ideal (O'Leary & Smith, 1991). Once established, Sager (1976) proposed that marital partners have an implicit contract to continue to gratify these needs throughout the marriage. Although this need-complementarity hypothesis of spouse selection has generally failed to be documented by research, it nonetheless continues to be a significant influence in shaping psychodynamic marital therapy (O'Leary & Smith, 1991).

The second central principle regarding marital adjustment held by psychodynamic therapists relates to the role played by each spouse's individual psychosexual development. The childhood attachment relationships each spouse had in his or her respective family of origin and especially the "lost aspects of their primary object relations" (Dicks, 1967) are presumed to be manifest in the current marital relationship. If comfortable differentiation from the family of origin and nonneurotic resolution of the various psychosexual conflicts has been achieved, positive levels of individual functioning and, subsequently, marital satisfaction can be expected (Framo, 1976). Some recent research appears to support this hypothesis in finding an association between attachment styles and romantic orientation (O'Leary & Smith, 1991).

With these as underlying precepts, insight-oriented marital therapies typically emphasize the resolution of conflictual emotional processes that exist either within one or both spouses separately, between spouses interactively, or within the broader family system. Developmental issues as well as current interactional patterns are identified and addressed in an attempt to integrate individual and systemic functioning. More specifically, the process entails a focus on "uncovering, interpreting and explicating the feelings, beliefs and expectations that spouses have toward themselves, their partners and the marriage, which are either totally or partially beyond awareness, so that these can be restructured or renegotiated at a conscious level" (Wills, Faitler, & Snyder, 1987, p. 686).

Unlike pure analytic therapy, insight-oriented marital therapy often involves a directive component, for example, giving input to change a couple's communication patterns directly or pointing out marital behaviors that are or are not helpful for marital satisfaction (Dare, 1986). Other therapists, while operating out of a dynamic conceptual framework, may also include interventions that are clearly behavioral (contracting, problem solving and communication training) or systems oriented (Gurman, 1978; Dare, 1986).

Outcome research. Four outcome studies involving insight-oriented marital therapy are reviewed in this section. Two studies show this approach to be minimally

effective and two show it to be significantly effective, including an evaluation at 4-years posttreatment.

Crowe (1978) conducted what is considered by most reviewers to be the earliest controlled outcome study evaluating the efficacy of nonbehaviorally oriented insight therapy. Forty-two couples, ranging in age from 25 to 62 years, were randomly assigned to one of three treatment conditions: (a) a directive approach emphasizing contracting based on Stuart (1969) and Liberman (1970); (b) an interpretive, insight-oriented approach, based on Skynner (1969, 1976); or (c) a supportive control condition in which the therapist attempted to avoid both advice-giving and interpretations. Treatments were standardized as far as possible with written instructions, and the number of sessions varied from five to ten. Assessment was primarily by self-report questionnaires as described below.

Using a 16-question self-report measure of marital adjustment (a portion of the Structured and Scaled Interview to Assess Maladjustment), the insight-oriented approach showed superiority to the control group only at nine months follow-up. It failed to show superiority to the control group immediately post-therapy, and at three month and 18 month follow-up. Measures of sexual adjustment, general individual adjustment and specific target problems also showed no significant difference between the insight-oriented approach and the control group. The directive

group, by contrast, was significantly superior to the control group on target problems, sexual adjustment and general adjustment both at the end of therapy and at follow-up. It was also superior to the interpretive approach on general adjustment at the end of treatment.

A significant issue regarding the insight-oriented approach in this study is that it specifically excluded directive, advice-giving interventions, in contrast to the approach from which it was derived. It has been suggested that this deficiency may account for the observed weakness of the insight approach in this study (Beach & O'Leary, 1985). In addition, the insight approach as used here did not explore the couple's families of origin, also somewhat of a deviation from the typical insight approach described above.

Another controlled outcome study was conducted by Epstein and Jackson (1978). Sixteen couples were randomly assigned to one of three conditions: (a) an interaction-insight group that emphasized increasing each spouse's awareness of the impact his or her behavior had on the other's feelings and behavior, with extensive feedback from the trainer but no directive advice for alternative behavior; (b) a communication treatment emphasizing assertion training and clear communication; and (c) a no-treatment waiting list. Couples in the treatment groups met for five one-and-a-half hour sessions over a three week

period. Both groups were led by the same male and female co-trainers, who were experienced in both formats and blind to the experimental hypotheses. Assessment at pre- and posttreatment involved a self-report scale of marital satisfaction (Barrett-Leonard Relationship Inventory) with the focus on empathy, congruence and unconditional positive regard received from the spouse, and ratings of communication on 11 categories of verbal behavior.

Results indicated that the insight-interaction group had a significant reduction in disagreement versus the control group, but no other significant changes from the control group were seen. The communication training group had a decrease in number of disagreements equal to the insight group, and in addition showed a significant increase in assertive requests relative to both the insight and control groups. Compared to the control group, the communication group also showed significant decreases in attack behavior and significant increases in spouse-perceived empathy.

The insight-oriented treatment in this study was more behaviorally focused than the previous study, but similar to the first study also specifically excluded offering directive input to the insight group couples about alternative behaviors. This again may be a significant reason why the insight group failed to show any significant change over the control group. L'Abate (1985) suggested

that improvement on 1 out of 14 measures demonstrated by the insight group could be anticipated on the basis of chance variability. Again, the insight treatment in this study appears to have been relatively ineffective.

Snyder and Wills (1989) randomly assigned 79 distressed couples to one of three conditions: (a) an insight-oriented marital therapy (conducted generally as described in the introduction to this section); (b) BMT as presented in Jacobson and Margolin (1979); and (c) a "treatment-on-demand" control condition, in which couples were not offered therapy until three months after initial evaluation but could obtain as many as three highly focused therapeutic consultations to help them tolerate the waiting period. Couples in the two treatment conditions met for an average of about 19 sessions. The five therapists had an average of eight years of experience post-masters, were trained and closely supervised by the author, and each conducted both treatment approaches with six couples in each approach. All of the therapists were without strong theoretical biases and subscribed to a pluralistic perspective. Assessment involved several self-report measures at both intake and termination including: (a) the Global Distress Scale of the Marital Satisfaction Inventory, (b) the Areas of Change Questionnaire, (c) the Minnesota Multiphasic Personality Inventory (MMPI), and (d) the Tennessee Self-Concept Scale.

Results showed both the insight-oriented and behavioral treatments to be generally equivalent in producing significant improvement in general marital satisfaction and to a lesser degree in individual psychological functioning. In the insight-oriented group, 73% showed significant improvement, with no couples deteriorating, versus 62% in the behavioral group with one couple deteriorating, and 15% in the control group and two couples deteriorating. The reductions in global distress were also equally maintained at six-month follow-up and continued to be significantly different from the control group.

Focusing on the insight-oriented group, the improvement rate (73%) compares favorably with the improvement rates reported above for BMT (55%) by Jacobson et al. (1984). It was not surprising that couples in both approaches showed essentially equal improvement in light of the findings of the meta-analysis studies previously cited. Because the collection of data did not allow for more specific study of the change process, and because there was no clear advantage for either treatment, no predictors of treatment success for the insight-oriented approach can be drawn from this study. Nonetheless, it can be concluded that the insight-oriented approach as conducted in this study is an effective treatment for distressed marital couples.

A follow-up study of 55 of the 59 treated couples in the previous study was conducted four years later by Snyder,

Wills, and Grady-Fletcher (1991). Only three of the original behavioral group couples and one of the insight group couples dropped out due to extenuating circumstances. The rest of the couples were contacted and interviewed by telephone, all separately from their partners. Divorced partners were also contacted and asked to complete questionnaire items except those relating to current interaction. Current marital status was the primary follow-up criterion: (a) happily married, (b) married but distressed, or (c) divorced. All subjects still married were asked to complete the Global Distress Scale, used to discriminate between happy and distressed couples. In addition, a seven-item questionnaire was administered that included questions regarding the marital relationship, individual problems and additional treatment since the original study.

The results of this study were quite surprising in light of the lack of differences at termination of treatment and six-month follow-up. In particular, 38% of the behavioral group couples versus 3% of the insight group couples had experienced divorce. BMT couples also showed significantly poorer long-term outcome when married-distressed and divorced categories were combined. Further, the behavioral group couples showed significantly higher rates of deterioration at four-year follow-up compared with status both at intake and termination. Responses to the other

questionnaire items showed no differences across treatment condition.

This study may point to strengths of the insight-oriented approach that could not be readily seen at the conclusion of treatment. The authors suggested that there were subtle and nonsignificant pretreatment group differences in global level of distress (behavioral group's scores being higher) that conceivably could contribute to the long-term differences, although other alternative explanations are possible. The lower deterioration and divorce rate for couples of the insight group may in fact suggest that it was better able to address the "internal events affecting the emotional qualities of the relationship" for which BMT has been criticized as less well suited (Hahlweg et al., 1984). Behavioral interventions such as problem-solving may promote short-term gain, but may not adequately facilitate the necessary intimacy to sustain the relationship without the accompanying insight, self-disclosure and attention to emotional issues that are more characteristic of insight approaches. Clearly, the specific reasons why the insight group fared better in the long-term cannot be determined from this or the previous study. But the results suggest that the efficacy of an approach may need to be determined over an extended period following treatment, rather than over the typical short-term period.

Summary. Based on the outcome studies above, insight-oriented marital therapy appears to be minimally effective when a directive component is not part of the treatment. When included, however, as in the last two studies, insight-oriented therapy appears not only to be significantly effective but may be even more effective than an early version of BMT in sustaining long-term gain. While one study (plus the follow-up) is not sufficient to substantiate this conclusion, the findings appear to suggest that addressing internal events, that is focusing on insight and emotional issues, may enhance problem resolution and marital stability. Without question there is a need for further empirical investigation of the active components of insight-oriented marital therapy.

Cognitive Marital Therapy

In the general cognitive model, an individual's emotional and behavioral responses to a stimulus (internal and external) are mediated by his or her perception and interpretation of the stimulus rather than elicited directly by the stimulus' objective characteristics (Meichenbaum, 1977). Applied to the marital relationship, it is proposed that the marital partners continuously provide stimuli for each other and actively appraise the behaviors they exchange. How they perceive and interpret and what they conclude about each other's behavior is determined by internal cognitive schemata, beliefs, attitudes,

expectations, and attributions. When there are distortions in these cognitive elements, personal and marital distress are frequently the result.

Theory and therapeutic interventions. The focus of cognitive marital therapy, therefore, is generally on identifying and directly modifying or correcting the faulty cognitions that each partner holds with the intent that more satisfying behaviors and feelings within the marriage will result. More specifically the therapy may focus on modifying distortions regarding (a) causal attributions or explanations for marital events or a spouse's behavior; (b) expectancies or predictions about the likelihood of future marital events; (c) assumptions or beliefs about the way that people in general, relationships, and one's partner are in actuality; or (d) standards or beliefs about the way that people in general, relationships, and one's partner should be (Baucom, Sayers, & Sher, 1990). Particular attention is given to problematic behavior and emotions or moods in order to understand the faulty underlying cognitions that are associated with them.

While there is a variety of styles and techniques that may distinguish different forms of cognitive marital therapy, each of them holds to the basic premises indicated above. As with the other nonbehavioral approaches, there are no purely cognitive approaches, as they may variously emphasize communication skills, relabeling, or behavioral

experiments to help correct faulty cognitions. Nonetheless, the following studies are presented with the goal of identifying the unique contributions of the cognitive approach.

Outcome research. In this section, six outcome studies are reviewed. The first three studies combine BMT with cognitive restructuring but show the cognitive component making a measurably significant contribution to the treatment in only one of the three studies. In the last three studies, the cognitive component is isolated as a treatment approach. One of these studies shows the cognitive treatment to be more effective than a control group, one demonstrates effectiveness equal to a behavioral treatment, and the third fails to prove more effective than a control group which had apparently also induced some mild therapeutic effects.

Margolin and Weiss (1978) conducted what may be conceptualized as an analogue outcome study due to the abbreviated nature of the treatment (four weekly sessions lasting two hours each). The study compared the effectiveness of behavioral-attitudinal (cognitive restructuring) treatment with a behavioral treatment focused on communication, using a third nonspecific effects group as a control. Twenty-seven distressed couples were treated by five paraprofessional therapists who were trained and supervised by the investigators. Assessment involved self-

report marital satisfaction inventories (Locke-Wallace Marital Adjustment Inventory; Area of Change Questionnaire), daily home observation using the Spouse Observation Checklist, and laboratory observation data using the Marital Interaction Coding System.

The behavioral (communication) group received communication training in which a raucous buzzer was sounded if one spouse thought communication was "unhelpful." The buzzer made a pleasant sound as reinforcement when one partner thought the communication of the other was helpful. The behavioral-attitudinal group used a similar buzzer, but sought to increase the number of times both partners thought the communication was helpful. In the behavioral group each partner tried to pinpoint specific positive behaviors that they wanted to have increased. Each then worked independently at increasing his or her own positive behavior corresponding to the spouse's wishes. The attitudinal-behavioral group had to agree together as a team on which behaviors they would increase.

The behavioral-attitudinal group also received some cognitive restructuring training from the therapist and readings, which consisted of such messages as, "the blame doesn't reside solely with one spouse." This cognitive restructuring goal was to help the couples reattribute the source of marital problems to "bad relationship skills" rather than "my spouse is bad." Thus the main differences

between the behavioral and behavioral-attitudinal group were (a) an emphasis on mutual rather than individual goals, and (b) reattribution of the behavior of each spouse.

The behavioral-attitudinal group demonstrated greater improvement than did the behavioral group on three out of the five measures used (Locke-Wallace Marital Adjustment Scale, daily home rating of pleasing behaviors on the Spouse Observation Checklist, and laboratory observation data assessing verbal and nonverbal communication processes). There were no significant differences between the groups on the Areas of Change Questionnaire or the Adjective Checklist. Both of the treatment groups showed greater improvement in overall marital satisfaction, specific pleasing behaviors and positive communication responses than did the non-specific treatment group.

In this study, the cognitive restructuring messages were essentially the only difference between the two treatment groups. The addition of the cognitive component appears to have increased treatment effectiveness, at least when combined with behavioral therapy. The brevity of the treatment, however, precludes the possibility of drawing many conclusions from this study of value to clinical practice.

Baucom and Lester (1986) assigned 24 distressed couples to one of three treatment conditions: (a) cognitive restructuring plus BMT, (b) BMT alone, or (c) a waiting

list. The behavioral therapy consisted of communication training, problem solving, and quid pro quo contracting as described above. The combined cognitive-behavioral therapy consisted of six weeks of training in cognitive restructuring followed by six weeks of behavioral therapy. For the cognitive restructuring component, the first three sessions focused on couples' attributions, the purpose of which was to help them view more realistically the multiple factors contributing to their marital problems. The next two sessions focused on spouses' extreme and unrealistic individual and relationship standards that interfere with marital functioning. The last session involved integrating the concepts of the first five sessions. The behavioral component over the last six weeks involved an abbreviated version of a full BMT approach.

Results of this study showed that cognitive restructuring plus BMT was equal to but not more effective than BMT alone. Both treatments showed significant improvements in overall marital adjustment and behavioral indices of change. Only the cognitive-behavioral group demonstrated consistent cognitive changes, but these were not significantly different from the behavioral group. Overall, approximately 50% of couples receiving treatment had moved into the nondistressed range of marital functioning by the end of treatment. The findings of this study are tempered by the fact that sample sizes were rather

small in each of the treatment conditions.

Baucom, Sayers, and Sher (1990) conducted a study with 60 distressed couples and compared the same treatment conditions as in the previous study: (a) cognitive restructuring plus BMT, (b) BMT alone, and (c) a waiting list. The procedures for these treatments were the same as in the previous study by Baucom and Lester (1986). In addition, this study also compared two other groups: (a) emotional expressiveness training together with BMT, and (b) BMT, together with cognitive restructuring as well as emotional expressiveness training. The cognitive restructuring in this latter treatment group was limited to three sessions. For the purposes of this review, the focus is on only the two treatments that included cognitive restructuring. The three doctoral students who served as therapists received extensive training in cognitive restructuring prior to this study, and weekly supervision during the study. Outcome measures, completed at pre- and posttreatment and at six-month follow-up, included several self-report and observational inventories used to assess behavioral, cognitive and affective variables, as well as global marital adjustment. Some of the specific measures are noted in the results reported below. In addition, a measure was used to insure that the therapists were adhering to the appropriate interventions.

All four of the active treatment conditions described above produced significant improvement in overall marital adjustment (using the Dyadic Adjustment Scale) compared to the waiting list couples. Focusing on findings pertinent to the cognitive treatment, only the men and women receiving the six-week cognitive restructuring showed significant improvement over the control group on both of the cognitive measures used (Relationship Beliefs Inventory; Irrational Beliefs Test). The group receiving three weeks of cognitive treatment showed no significant cognitive changes. The authors suggested that such brief exposure to cognitive training is probably ineffective. Of all the treatments, only men receiving the cognitive-behavioral combination did not improve in marital adjustment, and no explanations were offered for this finding. For comparison purposes only, BMT showed slight but nonsignificant advantage over the cognitive-behavioral combination (and other treatments as well) in percentages of both men and women showing improvement and entering the nondistressed range at the end of treatment.

Summarizing the previous three studies, the cognitive therapy component, when combined with BMT, failed in two out of three studies to show any therapeutic advantage over BMT alone, except perhaps on specific cognitive measures. The one study that showed the cognitive combination to be superior compared it to an incomplete behavioral package

(communication focused), though treatment was too short to be considered regular therapy. The findings of equivalence between different treatment packages would be likely in view of the previously cited meta-analyses. This does not rule out that the cognitive component may be effective for marital therapy, but rather suggests its effect may be masked by the limits of comparative outcome studies. Few conclusions can be made from these studies about the efficacy of the cognitive component, except that when it is combined with behavioral approaches, it appears to be equally effective as other more behaviorally oriented components for which it is substituted.

The next three studies examine the effectiveness of cognitive treatment apart from explicit behavioral approaches. Emmelkamp, van Linden van den Heuvell, Ruphan, Sanderman, Scholing, and Stroink (1988) compared the effects of communication skills training and cognitive therapy with 32 distressed couples. No control group was used. Seven advanced clinical psychology students served as therapists and were extensively trained and supervised. Outcome measures administered at pre-, posttest and one-month follow-up included several self-report questionnaires that assessed general marital adjustment (Maudsley Marital Questionnaire), communication (Communication Questionnaire), and cognitions (Relationship Belief Inventory; Irrational Belief Test). In addition, a list of three main target

problems was formulated by the couple and therapist together, and a behavioral measure of marital interaction using trained coders was conducted using videotape at pre- and posttest.

The cognitive treatment in this study was quite similar to the treatment in the two studies above and was based on Ellis (1977) and Beck (1980). It first involved cognitive restructuring focused on correcting the faulty causal attributions or explanations that distressed couples frequently give for events that take place in their marriages. The last five sessions focused on changing the irrational beliefs and unrealistic expectations that the couples might hold for the relationship. They were taught in the session and through use of homework to analyze their specific marital conflicts in terms of Ellis' ABC model and to replace their irrational beliefs with more constructive beliefs. The communication training had a skill-oriented focus with an emphasis on behavior change, generally following the process described above in the discussion of BMT.

Cognitive therapy alone in this study was found on most measures to be as effective as communication training. Both treatments showed significant improvement on most self-report measures at posttest, and these were maintained at follow-up. Despite improvements on various measures, however, overall marital satisfaction did not appear to be

impacted. An exception to this was for men in cognitive treatment who did show significant improvement. Cognitive therapy proved to be slightly superior to communication training on target problems for men and women, significantly so at follow-up. There were few differences between the treatments for improvement on the self-report measures specific to communication or cognitions. In contrast, the communication training resulted in significant improvement in negative verbal communication on the behavioral observation measure versus no significant improvement as a result of cognitive treatment.

The investigators noted that the treatments used in this study were both incomplete in terms of how they are usually conducted in clinical practice, and thus conclusions must be drawn with come degree of caution. Cognitive interventions were excluded from the communication treatment and behavioral interventions were omitted from the cognitive treatment, ostensibly to present each treatment in its purest form. Despite these omissions, it was interesting that equal gains were made by the two treatments on cognitive measures. These findings suggest that the effects of cognitive therapy may not necessarily be mediated by changes in cognitive processes. On the other hand, the cognitive treatment did not result in equal improvement in observed verbal communication, suggesting the possibility that a pure cognitive approach may be inadequate as a

clinical treatment of choice. Finally, the difference between the self-reports and observed communication for the cognitive treatment highlights the limits of self-report measures, at least in regard to knowing the true status of a couple's communication patterns. Once again, in light of the meta-analysis studies described earlier, the lack of measurable difference between the two treatments was not unexpected.

Huber and Milstein (1985) assigned 17 distressed couples to either a cognitive restructuring group or waiting-list control. The investigators themselves were the therapists in this study. One was an experienced Ph.D. level clinical psychologist, the other an advanced graduate student in counseling psychology who was extensively trained prior to and supervised during the study. Treatment couples met for an initial interview, six weekly 45-minute sessions, and one final "post-program" session to deal with any unfinished business. The treatments were educationally-oriented, with various readings and homework assigned each week aimed at modifying the unrealistic beliefs that the marital partners might hold. Control couples were administered pretest measures and told they would have to wait seven weeks. Four self-report measures were used at pre- and posttest to assess changes in overall marital satisfaction, individual and relationship beliefs, and attitudes about working on problems in the relationship.

Although the treatment was designed to be a preparatory treatment to create a positive collaborative set prior to behavior change strategies, the findings showed that significant therapeutic gain occurred during the six-week program. The cognitive restructuring treatment group showed significant gain compared to the control group on all the outcome measures, including overall marital satisfaction. The couples showed significant increases in positive expectations for therapeutic assistance and in desire to improve their relationship. Positive changes in both individual and relationship beliefs were observed, but only the beliefs about the relationships showed significant gain compared to the control group.

This study appears to confirm that a cognitive treatment which does not exclude behavioral interventions as part of its package can impact overall marital adjustment, in contrast to the previous study which utilized a stripped-down cognitive treatment. This conclusion needs to be held somewhat tenuously, however, because of the lack of any long-term follow-up in the study.

In a final study by Waring, Carver, Stalker, Fry, and Schaefer (1990), a standardized therapy known as Cognitive Marital Therapy (CMT) (Waring & Russell, 1980) was compared to a control group. CMT is a brief, structured treatment designed to enhance marital intimacy through facilitating cognitive self-disclosure. The therapist actively directs

the marital partners to disclose personal constructs (ideas, attitudes, beliefs) and their own theories as to why they are not close as a couple, and encourages exploration of their parents' and others' marriages. The therapist also directs couples to attend to their own thoughts about their partner's disclosures. Good listening skills are modeled and coached. Emotional reactions are discouraged, and feelings and behavior in general are not identified, confronted, or interpreted.

The control group in this study read one chapter per week from the same marital skills training manual used by the treatment group and disclosed their thoughts about the material each week to a research assistant. The assistant modeled listening skills and directed the couple to focus on particular passages as needed. Essentially the groups were quite similar except that the control group was less structured, more client-centered, and the research assistant had no formal training in the area.

Thirty-three distressed couples were assigned to one of these groups and couples in both groups met for ten weekly sessions. The outcome measures were all self-report inventories and included pre- and posttest measures of the marital relationship (Marital Satisfaction Inventory, Waring Intimacy Questionnaire, Self-Disclosure Questionnaire), and of personal presenting complaints (General Health Questionnaire, Symptom Check-List, Global Indices of

Distress).

Outcome measures showed no discernable differences between the marital therapy group and the control group in this study. Further, there was no significant improvement in either marital intimacy or marital satisfaction due to treatment. The only significant improvements noted were in symptoms of depression, and somatic and compulsive complaints, and these changes were equal for both groups. The authors reported that the majority of the couples evaluated their experience subjectively as positive and felt the sessions provided increased understanding and improved communication.

That the cognitive treatment did not demonstrate greater effectiveness than the control group may be due to the components in the latter having been more powerful than expected. Previous trials of CMT have shown its effectiveness in enhancing levels of intimacy, so it was suggested by the investigators that unique features of their sample may have hindered a similar positive effect in this study. In particular, the mean pretherapy scores on the WIQ of husbands and wives were very similar to population mean scores, which may suggest a possible restricted range of variance from pre- to posttherapy outcome scores. However, the lack of significant improvement by the primary treatment condition may again highlight the issue that a cognitive approach that does not also include sufficient behavioral

interventions, for example, communication training, may not be effective with marital couples. By its description, CMT does not appear to include many behavioral interventions. In addition, the therapy used in this study appears to restrict the couple from actively engaging and attending to emotional material, and this may also limit the treatment from producing gains in marital satisfaction and intimacy, as noted in the criticisms of BMT in an earlier section.

Summary. The variance in the designs of the studies cited above makes it somewhat difficult to compare their results. For that reason, conclusions must be viewed with caution. However, some general trends can be noted. The combination of the cognitive and behavioral interventions appears to be generally equivalent to the behavioral treatment alone in its impact on overall marital adjustment. While this finding is not unexpected (based on meta-analysis studies), it may suggest that the cognitive component is at least as effective as the behavioral elements it replaces when it is used together with a behavioral component. When cognitive treatments were relatively stripped of behavioral elements, however, overall marital adjustment was not significantly impacted. This may suggest that the purely cognitive approach alone may not be sufficient treatment for distressed couples. Finally, it might be expected that cognitive treatments would result in cognitive changes, and this was generally true when the cognitive treatment was six

sessions or longer. However, behavioral treatments also produced similar effects on cognitive change, which suggests that cognitive means are not the only way to mediate such change. Given the above observations, it appears that cognitive treatments should be combined with behavioral components in order to provide the most effective intervention for distressed couples.

Systemic Marital Therapy

The systemic approach to marital therapy owes its origin in the late 1950s to the rise of family therapy and its incorporation of basic aspects of general systems theory (L'Abate & McHenry, 1983). While more accurately there are several systemic approaches, the two distinct approaches of Jay Haley (Strategic Therapy) and Murray Bowen (Bowen Family Theory/Therapy) are considered by some to be the most prominent and most directly applied to couples (Baruth & Huber, 1984). For the purpose of this paper, however, these approaches are not elaborated or differentiated in preference for a more general overview of the systemic approach. The interested reader may find both of the noted approaches elaborated at length in other references (Bowen, 1978; Haley, 1976).

Theory and therapeutic interventions. Within the systemic approach, the marital dyad is viewed as an "ongoing interrelationship in which the actions and reactions of one individual influence the actions and reactions of another

individual" (L'Abate & McHenry, 1983, p. 326). Rather than hypothesizing a linear, individual cause-effect explanation of mental distress, marital interaction instead is considered to be nonlinear and often circular (L'Abate & McHenry, 1983).

Following from these concepts, intervention typically attempts to modify or disrupt the dysfunctional system or pattern of interaction. Depending on the therapist's systemic orientation, attention during therapy may focus on patterns of behavior and/or communication and the rules that govern them, the context of the couple's current problem (e.g., family life-cycle transitions, recent significant losses or changes, the role of the extended family system), or the functional aspects of the current symptoms, among various possible alternatives (Baruth & Huber, 1984). In Bowenian therapy the primary goal is increasing marital partners' differentiation of self, both individually from each other and from their families of origin. For Haley, the main goal is to get people to behave differently and as a result have altered and more fulfilling subjective experiences (Baruth & Huber, 1984). Where Bowenians tend more to teach and model behavior, strategic therapists attempt to actively induce behavior change by directly assigning tasks, or by employing paradoxical techniques such as prescribing symptoms, predicting relapses, or restraining change (Todd, 1986). There were no outcome studies found

that utilized Bowen's systemic approach, so the following studies primarily reflect the strategic systems approach.

Outcome research. In this section four outcome studies are reviewed. Two studies involved a "system-theoretic" approach and compared it to different components of BMT. The second set of two studies involved a more typical systems approach and evaluated the effect on treatment of two different process issues.

A study by Boelens, Emmelkamp, MacGillavry, and Markvoort (1980), referred to earlier, has been cited as an example of both insight-oriented (Beach & O'Leary, 1985) and systems-oriented (Baucom & Hoffman, 1986; Bednar, Burlingame & Masters, 1988) marital therapy. This confusion is understandable. The "system-theoretic counseling" utilized is reported to be based upon the work of a number of systems-oriented theorist/clinicians (Haley, 1973; Jackson & Lederer, 1969; Watzlawick, Weakland, & Fisch, 1974). However, the authors stated that its goal is "to provide partners insight into their overt or covert power-struggles" (p. 90), based on the hypothesis that insight will lead to a change in interaction and communication patterns. Because the emphasis appears to be on understanding and changing the interaction of the dyadic system rather than the individual, this reviewer has included it with the systems approaches, although there is obviously a merging of insight and systems approaches rather than a "pure" systemic approach.

In this study, 21 distressed couples were assigned to one of three conditions: (a) system-theoretic approach, (b) behavioral treatment consisting of reciprocity counseling, or (c) a waiting-list control group. Treatment in both conditions consisted of ten 60-minute sessions, with two sessions a week for the first two weeks. The waiting-list couples had no contact with the therapists during this time. Therapists were advanced clinical psychology students who were given extensive training. Assessments were conducted at pre- and posttest, and at one- and six-month follow-up. The outcome measures included three self-report scales (Maudsley Marital Questionnaire; Marital Deprevation (sic) Scale; rating scale of main target problems), ratings by an assessor (rated on affective relationship, marital distress, and problem solving skills), and direct behavioral observation (using the MICS, Marital Interaction Coding System).

The couples in the system-theoretic treatment were presented with models of three interaction-styles (complementary, symmetrical, parallel) from which they were helped to identify their own styles of overt and covert relating and to understand the power struggles that cause conflict. Once identified, they were then expected to more easily discuss the changes each spouse wanted in their relating style as a couple. They were instructed to think in terms of circular processes and urged to eliminate the

command aspects of communication which were relabeled as inadequate attempts to define the nature of the relationship. Homework emphasized changing the type of circular processes that were typical for the couple and paradoxical instructions were used frequently. Neither communication skills training nor contingency contracting was part of their treatment. The couples in the reciprocity counseling treatment focused on contracting training in which they established specific behavioral commitments for self and other, and compromise with each other. They did not receive any communication skills training.

Both treatment groups showed significant improvement compared to the control group on all self-report measures, and these improvements were maintained for the reciprocity counseling group at the six-month follow-up. Some of the couples in the system-theoretic treatment showed a relapse at the one-month follow-up, however, which may indicate that insight into systemic patterns alone was an insufficient treatment. No significant improvement was found through behavioral observations for either treatment. This may be partly due to the lack of focus on communication training, since the MICS emphasizes communication behaviors. For the system-theoretic group at the six-month follow-up, two couples had divorced, two showed no change, two were moderately improved and two were much improved. The other treatment group, in comparison, showed seven couples either

moderately or much improved. Clinical improvement was defined as the amount of change in Main Target Problems: (a) much improved, more than 50% change; (b) moderately improved, 25-50% change; and (c) no change, less than 25%.

In a second study by some of the same researchers (Emmelkamp, van der Helm, MacGillavry, & van Zanten, 1984), the intent was to determine if adding communication skills would improve the success rate of system-theoretic counseling. A crossover design was used, with distressed couples receiving seven sessions of system-theoretic counseling and seven sessions of communication training, with the order of treatment randomly varied. Therapists and assessment measures were the same as in the previous study, except that the tests were administered at an intermediate period as well and not at a six-month follow-up.

The system-theoretic treatment was conducted in the same manner as in the previous study. The communication-skills training initially utilized structured exercises (e.g., listening and empathy training, spontaneous expressing of feelings and assertiveness training), and later focused on the couple's own marital conflicts, with an emphasis on problem-solving training. Homework was also utilized.

Both treatments in this study resulted in significant and equal improvement on the self-report measures up to the posttreatment evaluation, and no further change was noted at

the one-month follow-up. Each treatment proved equally effective, and no significant differences were seen as a result of the treatment order.

In the first set of two studies, the overall findings are not unexpected for comparative outcome studies. The findings generally support the idea that systemic-theoretic counseling is as effective a treatment as two of the key components of BMT. However, these studies may not represent a systems approach as it is typically practiced (Gurman et al., 1986), thereby limiting the conclusion that a systems approach in general is an effective marital therapy. As noted earlier, these studies tended to emphasize the need for couples to understand the systemic patterns, which has led some researchers to classify them with insight-oriented approaches. The next two studies involved more traditional systemic approaches and focused on variables that impact their effectiveness.

Green and Herget (1989) evaluated the effects of systemic/strategic team consultation on marital and family therapy outcome. Eleven therapists selected two cases each from among couples already in treatment, couples that were considered to be difficult. These couples were then randomly assigned to either the team consultation group or a control group that continued to receive the same treatment as they had been receiving. Although nearly all of the cases involved couple issues, only ten cases were primarily

seen in conjoint therapy. In the other 12 cases the primary unit of treatment was an individual adult.

The team consultation approach in this study involved the therapist meeting one time with a group of other therapists for a five-part process: (a) a 45-minute pre-session meeting to present the case and develop clinical hypotheses; (b) a 50-60-minute period during which the treatment process was observed and videotaped by the team and hypotheses were explored by the therapist; (c) a 30-minute midsession team discussion (including the therapist) that was used to create a final intervention; (d) a 15-minute conclusion of the therapy session during which the intervention was delivered; and (e) a 30-minute postsession team discussion. The investigators described the team consultation model, its goals and subsequent interventions as particularly systemic/strategic and suggested it was clearly not interchangeable with the therapy provided in the control groups.

The outcome measures utilized in this study included (a) the Goal Attainment Scale (GAS) to evaluate the effectiveness of treatment; (b) the Client Rating of Change Questionnaire (CRC) on which the clients rate their global assessment of change toward goals; (c) the Therapist Rating of Change Questionnaire (TRC) on which the therapist gives a global rating of the client's progress toward therapy goals; and (d) the Family Environment Scale-Form R (FES), a 90-item

true-false instrument that measures the social environment of the family. The GAS and FES were administered both prior to the consultation and at one month post-consultation, while the CRC and TRC were administered only at one month post-consultation.

The results of this study showed that clients who participated in the team consultation were significantly more likely to achieve their main and overall treatment goals than clients who received only the regular therapy. The team approach did not lead to more positive changes on global measures of family functioning than were evidenced by the control group. Because it is not clear from the study how many couples were in each treatment group (compared to those who were primarily seen individually for marital therapy), some caution needs to be exercised in generalizing these results to treatment of marital couples in general.

Nugent and Constantine (1988) conducted a preliminary clinical investigation to explore the effect of individual preferences in marital paradigms on marital therapy outcome. Their study involved 103 distressed couples who had been seen in systems-oriented marital therapy by the first author during the years 1984 and 1985. The couples were an "unselected" group in that certain cases were not specifically picked for this study, but the group did not comprise a random sample. The investigator reported that they were "representative of the cases seen during that

time" (Nugent & Constantine, 1988, p. 355). Such a non-selection process does not seem to pose a threat to this study in light of the overall design for the research.

Outcome criteria were somewhat subjective due to the lack of useful instruments for assessing marital (or family) paradigms available at the time of this study. Nonetheless, the criteria for success of the marital therapy were systematically applied and were clinically meaningful. This is because the husband, wife and therapist all had to agree that the marriage was markedly improved based on the following: (a) divorce was not being considered or pursued, (b) individual marital dissatisfaction was low enough to be tolerated, and (c) discord and conflict were within acceptable bounds.

The underlying assumption of the Nugent and Constantine (1988) study was that couples tend to be organized and function in their marriage according to paradigms of how they believe the marital relationship is supposed to be conducted. The authors defined marital paradigms as "a model of what a marriage is, can be, and ought to be--an image as well as a point of view regarding how marriage and marriages are looked at" (p. 353). While couples may vary widely in their goals and strategies, it is suggested that these variations can be understood in terms of a few fundamental themes or basic paradigms that are derived from the priorities couples give to such elementary dualities as

continuity versus change and individual interests versus group interests.

According to the authors, there are four basic paradigms relevant to group functioning: closed, random, open, and synchronous. They can be defined more specifically in terms of the marital relationship as (a) closed/traditional, in which there is a clear hierarchy for authority and responsibility, roles tend to be fixed, the "good of the marriage" is put ahead of individual wants and wishes, and the general orientation is toward continuity and stability; (b) random/individualistic, in which the freedom and desires of the individual come before those of the couple, independence of thought and action and separate solutions to problems are the norm, organization tends to be egalitarian and anarchial, and the preference is toward change and novelty rather than stability and continuity; (c) open/verbal, in which couples emphasize talking things through to arrive at a solution agreeable to both partners, the individual and couple interests are both taken into consideration and negotiated, and organization is around adaptiveness, flexibility, and collaboration to allow for both stability and change; (d) synchronous/serene, in which peace and harmony in the relationship is of the highest value, problems are expected to work themselves out if left alone, open/verbal confrontiveness is avoided, and decisions made automatically because tacit agreement is understood and

needs are identical.

Each of these paradigms can be the basis for a successful relationship, though each has particular strengths and weaknesses that result in different experiences for the marital partners. When problems are encountered, couples tend to draw on the distinctive specialities unique to their paradigm. Unfortunately, even when the paradigm does not succeed, they tend to try harder at the same solutions, often leading to exaggerated or disabled expressions of that paradigm.

Based on the assumptions above, for the therapist to be successful in helping couples find the marital satisfaction they want, spouses must identify the paradigms each couple adheres to and utilize therapeutic strategies that take the paradigms into consideration. Because both partners in a marriage do not always share the same paradigm, each partner's preference has to be determined and blended interventions often need to be used. All of the couples, therefore, were presented in the initial session with the four basic marital and family paradigms above, and each partner was helped to identify the one that he or she most preferred. The therapist also formulated hypotheses about each individual's preferred paradigm. When the therapist's perception of the partner's preferred paradigm differed from the partner's choice, the options were explored until a consensus was reached between the therapist and the

individual partners.

On the basis of the outcome criteria used for this study, 72% (74 couples) of the couples were assessed as treatment successes. Outcome was found to be highly dependent on the paradigmatic basis of the marriage, with 92% (35) of the 38 couples with shared paradigms assessed as successful compared to only 60% (39) of the 65 couples with mixed paradigms. Additional trends shown in the analyses of data suggested that certain paradigmatic pairings were less likely to attain treatment success. This was particularly true for couples in which either or both partners preferred a synchronous/serene paradigm (especially when one spouse preferred a closed/traditional marriage), as well as for any couple in which only one partner favored a random/ individualistic relationship.

This study by Nugent and Constantine (1988) did not follow the typical research design of the rest of the studies in this review and did not utilize either a control group or standardized assessment methods. The overall effectiveness of systemic marital therapy therefore cannot be reliably concluded on the basis of this study despite the success criteria used by the investigators. Nonetheless, this study appears especially important as a prototype for future systems outcome research. Unlike most of the outcome studies reviewed above that treat all of the couples with essentially the same standardized interventions, Nugent and

Constantine took into account some of the individual differences that each couple presented in therapy and attempted to systematically apply types of interventions that were specific both to the couples' and individuals' needs and preferences. The criteria for therapeutic success, while not readily comparable to the previous studies, were clinically meaningful and were designed to accommodate the key values of each of the different marital paradigms. The findings suggest at least that therapeutic difficulties may be predicted early in the treatment process by giving attention to marital paradigms, especially when there are mixed paradigms involved. Needed for future formal research, however, are more reliable assessment methods for paradigms and means to measure marital satisfaction that take into account the different paradigms.

Summary. As can be seen from these studies above, there is very little marital outcome research to date that has focused on a systems treatment approach. The conclusions that can be drawn from these studies regarding the efficacy of the systems approach are as a consequence quite limited. If the first two studies are accepted as representing systems approaches, it appears that they are more effective than no treatment and about as effective as BMT. However, a systems approach that emphasizes insight as a primary goal may not maintain treatment gains as well as BMT.

The last two studies involve clearly more systemic approaches but offer less direct evidence for the general efficacy of systemic therapy because they focus on strategies to improve the effectiveness of systemic treatment. The team-consultation strategy appears to be significantly effective in helping couples already receiving systemic therapy to reach their treatment goals. It suggests that renewed attention to or clarification of a couple's systemic issues may enhance treatment progress, particularly for couples who are "stuck." Bagarozzi and Giddings (1983) have also suggested that a similar strategy of switching to strategic or paradoxical interventions is useful for extremely resistant couples and families who have refused to cooperate with a direct or behavioral approach.

Finally, from the Nugent and Constantine (1988) study, it may be concluded that early assessment of a couple's preferred marital paradigms can be useful in predicting treatment difficulties and in facilitating the therapist's choice of interventions. As instruments are developed that can provide reliable assessment of a couple's paradigmatic preferences, this strategy seems likely to be an asset to systemic as well as other marital therapy approaches.

Experiential Marital Therapy

The experiential approach to marital therapy, as with the other major modalities, encompasses and often blends a variety of more specific therapies (e.g., Gestalt, Neuro-

Linguistic Programming, Emotionally Focused Therapy). Experiential marital therapy is often combined with other approaches, particularly that of systems (Greenberg & Johnson, 1986). This section surveys the theory and therapeutic interventions of experiential marital therapy and reports on outcome research related to this modality.

Theory and therapeutic interventions. The basic theoretical orientation of experiential marital therapy is humanistic-existential, which focuses primarily on the client's inner subjective experience (e.g., feelings, attitudes, wants, perceptions, sensations, images) as the path to change, rather than on an objective and scientific reality (e.g., behavioral events). An underlying assumption is that there is a need within human nature to expand and integrate experience and that doing so leads to growth, increased self-direction, and positive changes in behavior and feelings (L'Abate & McHenry, 1983). This naturally occurring process of experiencing and awareness may become blocked through restrictions of awareness, avoidance, and the disowning of aspects of current experience and thus lead to individual dysfunction. When it occurs in the context of a marital relationship, negative interaction cycles may result, often leading to increasing marital dysfunction (Greenberg & Johnson, 1986).

Whereas individual Gestalt therapy tends to focus primarily on individual awareness, to the neglect of the

environmental context, experiential marital therapy seeks to address both (Greenberg & Johnson, 1986). The therapist's role is to provide an environment where the individual's basic feelings, attitudes and behaviors as well as the relational interaction sequences, themes and outcomes can be revealed. The therapist may employ a variety of methods including Gestalt exercises, sculpting, psychodrama, communication training and directives, to evoke old existing experiences and to create new ones. Through this process clients are confronted with their life patterns with present immediacy, areas of blocked awareness are explored, and the expression of new experiences and experimentation is generated. Stereotyped, entrenched patterns of behavior between the couple are broken as new experiences and perceptions of each other, themselves and the relationship are created and spontaneity returns (L'Abate & McHenry, 1983).

Outcome research. Five studies are reviewed in this section. The first study compared two treatments that have some similar experiential emphases, but with one having prominent skills training components as well. The other four studies were investigations of the efficacy of Emotionally Focused Couples Therapy (EFT), an experiential-systemic approach. Two of the four studies involved treatment outcome directly, while the last two focused on change process factors that appear to be the most

significantly related to effective EFT treatment outcome.

Jessee and Guerney (1981) compared a Relationship Enhancement (RE) approach to a newly developed Gestalt Relationship Facilitation (GRF) treatment using no control group. The authors stated that increased awareness of emotions, perceptions, values and feelings are goals of both approaches. However, GRF was designed to utilize Gestalt-based awareness and response processes to establish more effective and satisfying patterns of interaction and problem resolution between spouses. GRF provides a systematic process that emphasizes gaining self-awareness about individual and interpersonal behavior and learning skills necessary to establish and maintain a satisfying intimate relationship.

Relationship Enhancement, on the other hand, is designed to teach married couples specific skills of communication and problem-solving. Spouses are taught to express themselves constructively, state issues and feelings subjectively, express underlying feelings associated with implied criticisms, and state their desires and wishes as a basis for negotiation in problem-solving.

Thirty-six distressed couples were seen once weekly for 12 weeks in three-couple groups, with each session lasting two-and-one-half hours. Outcome measures in this study were administered pre- and posttreatment and included the Marital Adjustment Scale, Marital Communication Inventory, the

Interpersonal Relationship Scale, the Relationship Change Scale, the Handling Problems Change Scale, and the Satisfaction Change Scale.

Results showed that couples in both treatments improved significantly on all measures in the course of treatment. RE participants had higher mean gains than GRF subjects on all measures, reaching statistical significance on the Marital Communication Inventory, the Handling Problems Change Scale, and the Satisfaction Change Scale. Although the investigators have discussed some potential limitations to their findings, each is effectively ruled out. Without a control group, it is difficult to determine how effective these treatments are compared to no treatment, but both appear to be effective treatments. Perhaps more important in a study of this design, Relationship Enhancement appears to generate significantly more improvement than the GRF program in marital communication, in the ability to handle marital problems, and in increasing relationship satisfaction. This finding wculd appear to argue for the need in treating distressed couples to also emphasize the teaching of interpersonal skills (e.g., communication training, problem-solving) rather than intrapersonal awareness and expression alone.

Johnson and Greenberg (1985a) compared problem-solving training (a cognitive-oriented, primary element of BMT) to an affectively oriented, emotionally focused treatment and

to a waiting list control group. The emotionally focused treatment represented an integrated, affective-systemic approach, emphasizing the role of affect and intrapsychic experience, as well as the role of communication and interaction cycles in the maintenance of problems. The therapist in this approach identifies the negative interaction cycles and guides the couple in accessing the unacknowledged feelings underlying each person's position in the cycle. Rather than ventilation of feelings, insight or talking about feelings on a rational level, the process is a "synthesis of new emotional experience in the present" (Johnson & Greenberg, 1985a, p. 178), that is designed to promote new interactional positions. A more thorough description of this treatment approach, which is also referred to as Emotionally Focused Therapy, or EFT, is found in Greenberg and Johnson (1986; 1988).

Forty-five moderately distressed couples were randomly assigned to one of the three groups, 15 couples in each group. Couples in the two treatment groups participated in eight sessions of treatment and an eight-week follow-up. The control group couples were assessed after a two-month waiting period and were then treated. Outcome measures used in this study were administered at assessment, immediate posttreatment (except for control group) and at two month follow-up. The measures included the Dyadic Adjustment Scale (DAS), the Test of Emotional Styles (ES), the Couples

Therapy Alliance Scale (AS), Target Complaints (TC), Goal Attainment Scaling (GAS), and the Personal Assessment of Intimacy in Relationships Inventory (PAIR).

Results indicated that both treatment groups were significantly more improved than the control group on measures of goal attainment, marital adjustment, intimacy level and target complaint reduction. The emotionally focused group, however, scored significantly higher than the problem-solving group on marital adjustment, intimacy, and target complaint level. Further, the emotionally focused group maintained significantly higher scores on marital adjustment at the eight-week follow-up period. Overall, problem solving training with its largely cognitive emphasis was found effective, but the emotionally focused treatment was found to be more effective because of its emphasis on affect and the reciprocity of spouses' behaviors. These findings are particularly significant because, as noted previously, comparative outcome studies rarely demonstrate one treatment as significantly more effective than another. An additional finding in this study was that the emotionally focused treatment appeared to facilitate change in specific behaviors (as measured by target complaints) even though the focus was on emotional experience.

There were two primary limitations to conclusions that may be drawn from this study: (a) the senior investigator was also one of the therapists, and the orientation of the

investigator(s) has been found to be associated with research outcomes; (b) the moderate level of distress and high level of education of the couples may not allow the findings to be generalized to more severely disturbed, less educated couples. Apart from these limitations, this initial outcome study of emotionally focused treatment appears to demonstrate that an experiential approach can effectively improve marital adjustment and can address some of the couple's critical needs (e.g., facilitation of intimacy) in ways that BMT cannot do. In addition, this experiential treatment appears able to effect significant change in behavior and maintain treatment gains after therapy. These have been areas of weakness for some of the nonbehavioral treatments reviewed previously.

In another study, Johnson and Greenberg (1985b) provided the emotionally focused treatment for the couples in the control group of the previous study. The couples acted as their own controls, since on two previous assessments they showed no significant changes on measures of dyadic adjustment, intimacy, target complaint reduction and goal attainment. The 14 couples were randomly assigned in this study to seven master's degree students each of whom had received 12 hours of training in emotionally focused treatment intervention and who were supervised throughout the treatment period. The couples were seen for eight 75-minute sessions once a week as in the previous study, and

additional assessments were conducted at posttreatment and at eight-week follow-up. The results, as in the previous study, showed significant improvement on all measures at posttreatment. The overall effect obtained in this study was somewhat smaller than in the previous study, however, and this is thought to be largely attributable to the use of therapists who were relatively inexperienced in implementing the emotionally focused interventions. At the follow-up assessment only two measures (GAS and TC) were administered, with the sole significant effect being further improvement on target complaints.

The evidence derived from this study is consistent with the previous Johnson and Greenberg (1985a) study. It adds general support to the efficacy of emotionally focused treatment and to the proposition that focusing upon inner experience as it is translated into relationship events during an interaction can be a powerful tool for changing the quality of relationships. This study also lends support to the original finding that the emotionally focused treatment does seem to facilitate change in specific behaviors even though the primary focus of therapy is not behavior change but emotional experience. Finally, this study demonstrates that emotionally focused treatment can produce significant changes even when implemented by novice marital therapists, although experience with experiential interventions is likely to increase the effectiveness of the

treatment.

Greenberg, James, and Conry (1988) conducted a follow-up study with 21 of the couples in the two previous studies (Johnson & Greenberg, 1985a; 1985b) who had received the Emotionally Focused Therapy (now referred to as EFT). The purpose of the investigators in this new study was to identify processes of change in EFT that were related to treatment outcome from the couple's perspective through use of an exploratory, investigative approach called task analysis.

In order to develop a rational-empirical model of change processes, what clients actually stated as the element(s) they thought led to change provided the empirical data (for the empirical analysis), which was then compared to what the clinicians stated as the element(s) they in turn thought led to change (the rational analysis). Partners were first asked in a follow-up interview, approximately four months after termination of therapy, to describe incidents in therapy that stood out for them as helpful or not helpful and to describe how change took place in these incidents. Then sorters formed categories for these stimuli, and the categories were computer analyzed to disclose underlying or latent categories. Finally, the meaning of each of these latent categories was interpreted by the investigators, guided by the rational model.

The results of empirical analysis yielded five latent categories of significant change processes. The inferred meaning of each category and its assigned title are described as follows along with parenthetical statements that further clarify the process: (a) expression of underlying feelings leads to change in interpersonal perception (and produces interactional change); (b) expressing feelings and needs leads to the positive valuing of the expression of feelings and to the expression of needs and increased disclosure; (c) acquiring understanding (acquiring intellectual or emotional understanding or a combination of these by partner A leads to A relating differently to partner B); (d) taking responsibility for experience (results in a shift from attributing blame to taking a self-focus); and (e) receiving validation leads to change for the partner who receives validation and in the behavior of the partner who observes the process of validation.

Four of these client-identified change processes (i.e., b-e) are similar to processes frequently described in marital therapy literature (Greenberg et al., 1988). The first process, however, is not as often discussed in the literature and offers the most interesting implication of this study. It demonstrates the importance of studying what clients say about change to enrich the understanding of change processes in marital therapy rather than relying

solely on rational models. In particular, it suggests that the importance of expressing underlying feelings in couples therapy may lie in changing the partners' perceptions of each other (with resulting interactional change) rather than changing the individual's view of him- or herself. Stated differently, the communicative and interpersonal aspects of expressing underlying feelings are possibly more important than the intrapsychic aspect. The discovery of this process (a, above) seems to parallel, if not support, the findings of the Johnson and Greenberg (1985a) study that showed greater change was achieved when emphasis was placed on intrapsychic awareness together with the active communication of feelings rather than on intrapsychic awareness alone.

In a study with a slightly different focus, Johnson and Greenberg (1988) attempted to analyze the process of change in the "best" sessions of EFT. This time the focus was on identifying the characteristics of client performance which led to successful outcome. Out of the subject pool of the 29 couples treated with EFT in the second and third studies above, six couples were selected for intensive study. Three of the six couples were those who had shown the greatest change on the Dyadic Adjustment Scale (DAS) (average of 47 points change) from pre- to posttreatment, and three were those who had shown the least change on the DAS (average of two points). Two instruments were used by blind evaluators

in this study for rating client performance in the couples' previously videotaped so-called best sessions. Depth of experiencing was measured by the Experiencing Scale (ES) and the quality of interpersonal interaction was assessed by the Structural Analysis of Social Behavior (SASB).

The conclusions drawn from the Johnson and Greenberg (1988) study are limited by small sample size and the correlational nature of the study. However, the results suggest that three processes appear to be important elements in successful experiential therapy: (a) a high level of experiencing that involves the exploration and reprocessing of emotional experience, (b) the facilitation of disclosing and affirming interactions, and (c) the creation of a softening event. A softening event is one in which a blaming or pursuing spouse accesses and discloses his or her own vulnerability and as a result replaces hostile or coercive behavior toward the opposite spouse with more affiliative and accepting behaviors (e.g., asking for closeness or comfort from a previously distant partner).

Summary. As has been the case for the other nonbehavioral approaches reviewed, there are few outcome studies of experiential marital therapy from which conclusions can be drawn. That four of the five above-mentioned studies were conducted by the same investigators and deal with a specific type of experiential therapy further limits general conclusions that can be made about

the experiential approach as a whole. However, a few general conclusions and trends seem warranted.

Essentially only two experiential approaches were utilized in the five studies, e.g., the Gestalt Relationship Facilitation (GRF) and the Emotionally Focused Therapy (EFT), and both demonstrated a degree of effectiveness with distressed couples. Conclusions are rather weak regarding GRF because there was no control group and only a single study was conducted, yet the general finding was that it was significantly less effective than a treatment that emphasized communication skills training.

Emotionally Focused Therapy, on the other hand, was demonstrated to be significantly superior to a behavioral treatment emphasizing training in problem-solving skills, and its effectiveness was replicated in a second study as well. While there was no way to directly compare GRF and EFT, the latter has been more thoroughly researched and appears to be a more effective treatment.

From the investigators' descriptions of each of these treatments, GRF appears to be more limited to an experiential focus, whereas EFT also emphasized attention to the broader systemic patterns and effective communication. It seems likely that these emphases make the experiential treatment more effective in general, because they expand the focus from primarily intrapersonal factors to include more interpersonal and behavioral dynamics that are central to

marital functioning. The therapist in EFT is also clearly active in guiding, reframing and helping the partners connect their inner experience with overt behavior. This directive function has previously been found to be a significant factor for the effectiveness of insight-oriented therapy, and it is likely that it contributes to the efficacy of this similar experiential therapy.

Perhaps the most important implications of the last two studies are that they attempt, through empirical demonstration, to begin (a) to describe and explain change processes and (b) to construct a model of change in marital therapy. Models of change are vital for the marital therapy field not only to continue to develop but also to begin to differentiate which strategies and interventions are most effective with which clients at particular times in therapy.

Most of the studies referred to in the present paper demonstrate that there is an approach that is effective with distressed couples. Though this may be useful to know, the actual change processes that account for their effectiveness are largely unknown. Different approaches appear to be of essentially equal effectiveness. This may lead to a possibly erroneous conclusion that it does not matter what interventions are used. As different therapeutic approaches increasingly utilize common strategies and interventions and become less differentiated from each other, this "shotgun" approach to marital therapy tends to further obscure

effective change processes and hampers the tailoring of specific therapeutic models and techniques to particular client needs. Clearly, the shift in research toward the change processes appears to be a beneficial and needed step in fine-tuning marital therapy for more effective treatment outcome.

SUMMARY AND CONCLUSIONS

This paper has reviewed outcome research for four nonbehavioral approaches to marital therapy. The relative efficacy of each approach has been summarized, and strengths and limitations of each treatment type have been discussed. The findings are summarized briefly here.

1. Insight-oriented marital therapy appears to be at least minimally effective when directive interventions are excluded from the treatment. When included, one insight-oriented approach appears to offer a therapeutic efficacy equal to that of BMT (as far as can be determined by comparative outcome studies), and perhaps superior to BMT in respect to long-term gains. It is suggested that the demonstrated efficacy through the long-term may be due to the ability of insight-oriented approaches (and nonbehavioral modalities in general) to better address the internal events that affect the emotional qualities of the relationship.

2. Cognitive marital therapy also appears to be relatively ineffective when behavioral interventions are excluded from the treatment. When cognitive treatments are combined with behavioral interventions, the treatment appears to be as effective as other behavioral treatments. Cognitive treatments show some strength in effecting cognitive changes, though it appears that behavioral treatments may also mediate similar changes.

3. The findings for systemic marital therapy must be viewed as tentative because there were only two direct outcome studies and both utilized a somewhat disputable, insight-oriented form of systemic therapy. These treatments were generally as effective as the behavioral components to which they were compared, but they showed a tendency toward greater deterioration of treatment gains. Two other studies offered support for interventions that increase the effectiveness of systemic marital therapy; these interventions may be adaptable as well for other approaches.

4. Two models of experiential marital therapy were reviewed, Gestalt Relationship Facilitation and Emotionally Focused Therapy, and both evidenced a measure of effectiveness with distressed couples. Multiple studies with EFT add greater significance to its findings and suggest that it is likely the superior of the two. EFT is an experiential-systemic treatment that was shown to be significantly more effective than a behavioral problem-

solving approach, particularly on measures of marital adjustment, intimacy and target complaint level. Further, EFT maintained these gains over a two month period. The therapist's experience level with experiential interventions appears to be an important factor in achieving optimum results with EFT. Finally, change processes involved in EFT were examined and found to generally support the importance of experiential processes and events for therapeutic success.

The number of nonbehavioral outcome research studies has increased since publication of previously cited reviews, but it appears that there are still many more studies needed. Only tentative conclusions can be drawn from many of the studies reviewed above until additional and more relevant studies are conducted that will either confirm or disconfirm their basic efficacy as marital treatments. Once their effectiveness in increasing marital satisfaction has been more clearly documented, more advanced issues need to be addressed for those treatments.

The change process research done with Emotionally Focused Therapy is a good example of such research, as it focuses on identifying the critical variables that actually influence change, thereby allowing future therapy to become more precise in applying the interventions. Future outcome research needs to better match couples to interventions used rather than randomly assigning couples to treatment. The

study by Nugent and Constantine (1988) appears to be a positive step in that direction, although as noted, such research requires more exacting measures to adequately differentiate between couples on clinically meaningful variables.

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